

**THE NATIONAL PRACTITIONER DATA BANK:
HARMFUL OR HELPFUL IN THE HANDS OF THE CONSUMER?**

by
Connie J. Bullock
Spring, 2001

DISTRIBUTION STATEMENT A
Approved for Public Release
Distribution Unlimited

Health Care Law
LL.M. Candidate
DePaul University College of Law

20010816 049

AQM01-10-2255

**THE NATIONAL PRACTITIONER DATA BANK:
HARMFUL OR HELPFUL IN THE HANDS OF THE CONSUMER?**

INTRODUCTION	1
I. THE HEALTH CARE QUALITY IMPROVEMENT ACT AND THE NATIONAL PRACTITIONER DATA BANK (NPDB)	5
A. History.	5
B. Data Bank Contents and Use	8
II. OPPOSITION TO PUBLIC ACCESS TO THE NPDB.	13
A. Confidentiality of NPDB Contents	14
B. Medical Malpractice Payment Reports.	16
C. Using the Department of Defense Model as an Alternative Medical Malpractice Reporting Process.	22
III. ADDITIONAL DEFICIENCIES PLAGUE THE NPDB.	29
A. The GAO Report: Inaccurate, Incomplete, and Untimely.	29
B. NPDB Annual Report 1999.	32
1. The Corporate Shield Loophole.	33
2. Underreporting of Hospital Privileging Actions	35
IV. POSSIBLE ALTERNATIVE SOURCES OF PUBLICLY ACCESSIBLE PHYSICIAN PERFORMANCE INFORMATION.	39
A. The Federation of State Medical Boards	40
B. State Initiatives.	46
CONCLUSION	49

THE NATIONAL PRACTITIONER DATA BANK: HARMFUL OR HELPFUL IN THE HANDS OF THE CONSUMER?

Connie J. Bullock*

INTRODUCTION

The Internet's powerful ability to quickly disseminate vast amounts of information to so many people has changed every aspect of our lives, including how we "shop" for medical care. For years, patients wanting disciplinary information on their physicians had to write to their state medical board to request it. Since the advent of the World Wide Web, the same information that ten years ago would have taken weeks to track down and obtain is often accessible by entering a few simple computer keystrokes.

In an effort to meet the public's demand for information on physicians and their practices, on September 7, 2000, Representative Tom Bliley (R-Va)¹, Chairman of the House Commerce Committee, introduced the Patient Protection Act of 2000². His proposal sought to amend the Health Care Quality Improvement Act of 1986 (HCQIA)³ by allowing public access to health care practitioner information reported to the National Practitioner Data Bank (NPDB) -- a creation of the HCQIA. Under current regulations, the data bank's contents are open only to those whose records are at issue and to

* LL.M. Candidate, 2001, DePaul University College of Law; J.D., 1990, Florida State University, College of Law. Lieutenant Commander Bullock is currently on active duty with the United States Navy, and is a member of the Judge Advocate General's Corps. The opinions expressed in this article are solely those of the author.

¹ Congressman Bliley has since retired.

² Patient Protection Act of 2000, H.R. 5122, 106th Congress. As of April 17, 2001, no similar bills had been introduced during the 2001-2002 Congressional session.

certain health care providers to furnish supplemental information for use in the decision-making processes accompanying physician hiring and privileging actions.

Opponents severely criticized the proposal claiming, among other things, that its introduction was a political maneuver designed to redirect attention from the Patients' Bill of Rights⁴ (which, at the time, was stalled in negotiations in both houses of Congress), but Representative Bliley defended his proposal. The information available in the data base is needed because, he said, "with so many people covered by HMO's, they may well not know the surgeon who is about to operate on them."⁵ It is "unconscionable that consumers have more comparative information about the used car they purchase or the snack foods they eat than the doctors in whose care they entrust their health and well-being."⁶

As practically motivated as Representative Bliley may have been, he was forced to grapple with the fine line that exists between providing information that is helpful and that which is harmful to the consumer. His opponents quickly pointed out that it is not always the case that "the more information available about 'health care providers' (physicians, hospitals, insurance companies, etc.) irrespective of its content, the better off patients will be."⁷ Representatives of the American Medical Association

³ The Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11101-52 (1995) (HCQIA). The HCQIA was approved as Title IV of Pub. L. 99-660, 100 Stat. 3784 (1986).

⁴ Susan J. Landers, *AMA Renews Attack on Bill to Open National Practitioner Data Bank*, American Medical News, Sept. 25, 2000, <http://www.ama-assn.org/public/journals/amnews/amnews.htm>.

⁵ *Id.*

⁶ Associated Press, *Database Tracks Doctors' Problems* (June 29, 2000), <http://msnbc.com/news/427175.asp>.

⁷ American Medical Association (AMA) Board of Trustees Report 31-I-00 from D. Ted Lewers, M.D., Chair, Board of Trustees, to David T. Hannan, M.D., Chair,

(AMA) and the American Hospital Association (AHA), the two most vociferous opponents of the proposal, questioned whether disseminating the kind of raw, non-synthesized data available through the NPDB would help the HCQIA and the NPDB meet their common goal of improving the quality of health care.⁸ Instead, they suggested that reports on credentials and privileging actions would provide a more accurate reflection of a physician's competence than would the medical malpractice payment reports which make up the bulk of NPDB entries, the latter of which are easily subject to misinterpretation.⁹

Representative Bliley's proposal eventually died in committee, but it is doubtful that at the time of its introduction, he could have imagined the amount and kind of critical attention his bill would focus on the National Practitioner Data Bank. Critics of his bill offered but a glimpse into the many problems which plague the NPDB which, according to several recent reports, make it unreliable as a consumer resource for information on health care practitioners. Both sides of the debate seemed to agree that patients have a right to know information about disciplinary actions and "properly expressed" malpractice payments¹⁰ concerning a physician who is taking care of them. The problem, however, is in finding and agreeing on the best resource to provide it. Rather than look to the NPDB, many used Representative Bliley's proposal to argue that consumers should look to State medical boards

⁸ Reference Committee B (Dec 4, 2000) at <http://www.ama-assn.org/meetings/public/interim00/reports/hodactions/annocb.pdf>.

⁹ *Public Availability of Physician Information in National Practitioner Data Bank: Hearing on H.R. 5122 Before the House Comm. On Commerce, 106th Cong.* (2000) (statement of Richard F. Corlin, M.D., President-Elect, American Medical Association); *Public Availability of Physician Information in National Practitioner Data Bank: Hearing on H.R. 5122 Before the Subcomm. on Oversight and Investigations of the House Comm. On Commerce, 106th Cong.* (2000) (statement of Rodney Hochman, M.D., Chief Medical Officer and Senior Vice President, Sentara Healthcare). Both of these statements are unpublished, but are available online at http://www.access.gpo.gov/su_docs/legislative.html.

¹⁰ *Id.*; see *infra* notes 33-36, 60-61 and accompanying text.

¹⁰ See *infra* notes 61-63 and accompanying text.

or private sector organizations which have either been tasked with or voluntarily undertaken collection of licensure and disciplinary information on their licensees.¹¹

There remains a strong public demand for accurate, reliable, relevant, and contextual information on health care providers, but how do we strike the balance between helpful and harmful consumer information? How do we provide what consumers want, and reconcile that with the competing concerns which control accessibility?

To better understand the recent debate and concerns over the content of the NPDB, Part I of this paper will review the history of the NPDB and its status following 10 years of operation. Part II will focus on the specific concerns that opponents of Representative Bliley's bill voiced including data bank confidentiality, and the unreliability of medical malpractice payments as indicators of physician competence. Part II will also provide details on the reporting process used by the Department of Defense, a process suggested by some of the opponents as a potential "fix" for indiscriminate reporting of malpractice payment awards. Part III will focus on some of the problems recently identified by the General Accounting Office and by the NPDB in its Annual Report for 1999. The problems include underreporting of clinical privileging actions, and use of the "corporate shield," the latter of which has resulted in underreporting of potentially thousands of malpractice payment reports. Part III also discusses some of the proposals that have been suggested to increase the data bank's reliability, including additional sanctioning authority for failures to report adverse hospital privileging

¹¹ *Public Availability of Physician Information in National Practitioner Data Bank: Hearing on H.R. 5122 Before the Subcomm. on Oversight and Investigations of the House Comm. On Commerce, 106th Cong. (2000) (statement*

actions. Finally, Part IV provides a brief overview of suggested alternatives to opening the NPDB to the public, specifically, use of state-based data banks and the Federation of State Medical Board's (FSMB) new "DocInfo" Internet website, which is a result of the Federation's All Licensed Physician's Project (ALPP).¹²

I. THE HEALTH CARE QUALITY IMPROVEMENT ACT AND THE NATIONAL PRACTITIONER DATA BANK

A. History

The Health Care Quality Improvement Act of 1986 (HCQIA) was enacted on November 14, 1986 following Congress' determination that there was a "national need to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance."¹³ Congress believed that a national data bank would help to curtail the potentially harmful effects of such nondisclosure and thus authorized the Secretary of Health and Human Services (HHS) to establish the National Data Bank.¹⁴ The objective of this newly-created data bank was to decrease the degree to which unethical or incompetent physicians, dentists, and other types of health care practitioners could negatively impact the quality of health care in the United States.¹⁵

of the Hon. John D. Dingell) at
http://www.access.gpo.gov/su_docs/legislative.html; Corlin, *supra* note 8.

¹² Corlin, *supra* note 8.

¹³ 42 U.S.C. § 11101.

¹⁴ The name, "National Data Bank" was later changed to "National Practitioner Data Bank."

Regulations governing the operation of the National Data Bank
(hereinafter referred to as the National Practitioner Data Bank or "NPDB")
were finalized on October 17, 1989.¹⁶ In many respects, the NPDB would
duplicate the kinds of data already collected by State licensing boards and
other private sector and nonprofit organizations, but at the time of the
Act's conception, there was concern that States did not have the necessary
resources to advance the initiatives proposed by the HCQIA and none of the
data banks in existence had access to the specific kinds of information
contemplated for collection by the NPDB. Once operational, the NPDB became
the only nationally based, central repository for information on physicians
and other health care practitioners concerning medical malpractice payments
and certain adverse actions concerning licensure, clinical privileges, and
professional society memberships.¹⁷

In order to obtain physician information, the NPDB relies on mandatory
reporting requirements imposed on a variety of entities. The criteria for
filing reports with the data bank generally relate to the particular entity's

¹⁵ HCQIA of October 17, 1989, *supra* note 3.

¹⁶ 45 C.F.R. Subtitle A Part 60 (2000).

¹⁷ *Id.* In addition to professional liability payments, the NPDB collects and disseminates the following information in accordance with 45 C.F.R. Subtitle A Part 60 (2000):

- a. Adverse action reports based on professional competence or conduct that adversely affects privileges for more than 30 days. These actions include reducing, restricting, suspending, revoking, or denying privileges, and include an entity's decision not to renew privileges if the decision was based on competence or professional misconduct. It also includes voluntary surrender or restriction of privileges either while under investigation or in lieu of an investigation;
- b. Disciplinary actions related to competence or professional misconduct taken against a license to practice, including revocation, suspension, censure, reprimand, probation, and licensure surrender; and,
- c. Professional society review actions taken for reasons related to competence or professional misconduct that adversely affect membership in the professional society.

area of responsibility.¹⁸ For example, insurance companies report practitioners for whom medical malpractice payments have been made.¹⁹ State licensing boards report practitioners who have been disciplined. Likewise, professional societies are required to report actions that adversely affect a practitioner's membership in the society. Health care providers, including both hospitals and health plans, report restrictions of a practitioner's clinical privileges when the restriction is for more than 30 days as well as malpractice payments made from their own funds.

Over the years, the mandatory reporting requirements originally established by the HCQIA of 1986 have been substantially expanded. The Medicare and Medicaid Patient and Program Protection Act of 1987, as amended, requires states to report licensure actions taken against nurses and other state-licensed health care practitioners to the NPDB.²⁰ In 1997, an agreement between the Department of Health and Human Services Office of Inspector General (HHS/OIG), the Health Resources and Services Administration (HRSA), and the Health Care Financing Administration (HCFA), imposed a requirement that practitioners who were excluded from participation in Medicare or Medicaid programs due to fraud and abuse activities also would be reported to the NPDB.²¹ Lastly, a Memorandum of Understanding between HHS and the Department of Justice's Administrator of the Drug Enforcement Administration

¹⁸ 42 U.S.C. § 11111-33.

¹⁹ 45 C.F.R. § 60.7(a); but see Am. Dental Assn. v. Donna E. Shalala, 3 F.3d 445 (D.C. Cir. 1993) (holding the reporting requirement does not include self-insured individuals).

²⁰ The Medicare and Medicaid Patient and Program Protection Act of 1987, Pub. L. No. 100-93 § 1(a), 101 Stat. 689 (1987).

²¹ Amendments to OIG Exclusion and CMP Authorities Resulting From Pub. L. 100-93, 57 Fed. Reg. 3298 (Jan. 29, 1992).

(DEA) imposed a requirement on DEA to report actions to revoke or suspend a practitioner's registration to dispense controlled substances to the NPDB.²²

Although the problems that the legislation was intended to address were not peculiar to the civilian health care sector, the mandatory reporting provisions established by the HCQIA were inapplicable to the federal government. To address this gap, section 11152(b) of the Act required HHS to enter into Memoranda of Understanding (MOUs) with the Department of Defense and the Administrator of Veterans' Affairs. The intention behind section 11152(b) was to prevent physicians from circumventing the objective of the HCQIA by crossing from federal to private practice (and vice versa) in order to avoid detection of reported events.²³ Details of the resulting MOU and DoD's reporting process appear later in this paper.

B. Data Bank Contents and Use

It is obvious that the types of information contained within the data bank could affect a variety of aspects of a practitioner's livelihood, including licensure, medical staff positions, future insurability, and contractual arrangements (with, for example, HMOs). Because knowledge of its contents carries considerable potential for adverse affects, the statute designated the NPDB as a confidential "System of Records" under the Privacy Act of 1974 and provided its administrator (HRSA) with penalty authority for

²² 42 U.S.C. § 11152(c); see also NATIONAL PRACTITIONER DATA BANK, 1999 ANNUAL REPORT, at 4, available at <http://www.npdg-hipdb.org/pointer/npdb.html>.

²³ Act of November 14, 1986, Pub. L. N. 99-660, § 302, 1986 U.S.C.C.A.N. (99 Stat.) 6384, 6404-5.

a variety of infractions.²⁴ For example, authorized queriers (discussed infra) who receive information from the NPDB must use it for the purpose for which it was intended or subject themselves to a civil monetary penalty of up to \$10,000 for each violation.²⁵ Criminal penalties, including both fines and imprisonment, may be assessed against those who willfully query the NPDB under false pretenses or fraudulently gain access to NPDB information.²⁶ Civil penalties of up to \$10,000 can also be assessed for each failure to report a medical malpractice payment,²⁷ but there are currently no financial penalties for states, health care providers, or federal agencies that do not report clinical privileging restrictions against practitioners.²⁸

The confidentiality provisions did not interfere with the goal of the Act since, from the time of its creation, the NPDB's information was intended to supplement other relevant data used by health care providers in the decision-making process which accompanies privileging and employment decisions. As such, under current regulations, the data bank's information is available only to registered, eligible entities, upon request, with the sole purpose of serving as a flagging mechanism for physician competence and professional misconduct problems.²⁹ Some entities, including state licensing boards, professional societies and other health care entities which conduct peer review activities (including HMOs, PPOs, group practices, etc.), may make voluntary queries, while others, such as hospitals, must query the NPDB whenever a practitioner applies for clinical privileges and every two years

²⁴ 42 U.S.C. § 11131-37.

²⁵ 45 C.F.R. § 60.13 (2000).

²⁶ 5 U.S.C. § 552a(i)(1) (1995).

²⁷ 45 C.F.R. § 60.7 (2000).

²⁸ GENERAL ACCOUNTING OFFICE, GAO-01-130, NATIONAL PRACTITIONER DATA BANK: MAJOR IMPROVEMENTS ARE NEEDED TO ENHANCE DATA BANK'S RELIABILITY, at 10 (2000), <http://www.gao.gov/new.items/d01130.pdf>.

²⁹ NATIONAL PRACTITIONER DATA BANK, 1999 ANNUAL REPORT, *supra* note 22, at 2.

for practitioners already on staff.³⁰ Individual practitioners may conduct self-queries, but malpractice insurers, advocacy groups, and the public are currently prohibited from querying the data bank for physician specific information.³¹

As of December 1999, the data bank contained 227,541 reportable actions, malpractice payments, and Medicare/Medicaid exclusions, involving 145,537 individual practitioners.³² Cumulatively, malpractice payments total nearly 173,000 or approximately 76% of all reports.³³ Reportable actions involving licensure, clinical privileges, professional society membership, and DEA actions cumulatively represent nearly 19% of all reports received since the data bank's inception.³⁴ Standing alone, clinical privilege restrictions comprise less than 4% of the data bank's cumulative total.³⁵ The remaining 5% of the data bank's reports represent the approximately 13,000 Medicare/Medicaid exclusions since reporting became mandatory in 1997.³⁶

From September 1990 through December 31, 1999, the NPDB responded to over 19.3 million queries with a match rate (a query concerning a

³⁰ 42 U.S.C. §§ 11135, 11137.

³¹ Members of the public may, however, purchase a public use data file from the NPDB. The public use file contains one complete record for each malpractice report or adverse action report in the data bank. The file is devoid of any information which identifies a specific practitioner, but does provide the state of residence, licensure, and employment, field of licensure, age group, graduation year, malpractice payment amounts and number (single or multiple), number of practitioners included in a payment, and whether the payment was the result of a judgment or settlement. Adverse action information includes the classification of the action, as well as the length and year of the action.

³² NATIONAL PRACTITIONER DATA BANK, 1999 ANNUAL REPORT, *supra* note 22, at vi.

³³ *Id.*

³⁴ *Id.* at vii.

³⁵ GENERAL ACCOUNTING OFFICE REPORT, GAO-01-130, *supra* note 28, at 18.

³⁶ NATIONAL PRACTITIONER DATA BANK, 1999 ANNUAL REPORT, *supra* note 22, at vi.

practitioner who has one or more reports in the NPDB) of 9.8%.³⁷ Standing alone, the year 1999 resulted in a 12.5% match rate.³⁸ During the five-year period of 1995 through the end of 1999, both voluntary and mandatory queries increased, but the former has been much greater.³⁹ In light of the structure of our health care delivery system, with its burgeoning number of managed care organizations, the increase in voluntary queries is not surprising.⁴⁰

While the data bank's statistics are impressive, one must still ask whether their compilation helps the NPDB in achieving its intended goal: to improve the quality of health care in the United States. The NPDB Annual Report in 1999 stated that licensing authorities and peer reviewers can use the practitioner-specific data to make licensing and credentialing decisions which has the resultant and general effect of benefiting and protecting the public.⁴¹ Two additional surveys, one in 1995 and the other in 1997, separately found that the majority of entities using the NPDB rated it as an important source of information for their peer review activities.⁴²

³⁷ *Id.* at viii.

³⁸ *Id.* If one extrapolates the data from the NPDB Annual Report for 1999, using the lowest fee applicable to a query (\$4 for electronic queries; a \$3 surcharge applies for queries submitted on diskettes and self queries are \$10 per data bank search), the cost per match exceeds \$32 (3,222,348 queries x \$4.00 = \$12,889,392 ÷ 401,277 matches = \$32.12 per match).

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ *Id.* at 3.

⁴² NATIONAL PRACTITIONER DATA BANK: USER SATISFACTION WITH REPORTING AND QUERYING AND USEFULNESS OF DISCLOSURE INFORMATION FOR DECISION MAKING 1992 - 1994 (Health Resources and Services Administration, U.S. Department of Health and Human Services, 1995); W. E. Neighbor et al, *Rural Hospitals' Experience with the National Practitioner Data Bank*, 87 Am. J. Pub. Health 663, 663-66 (1997) (Study involved 149 hospitals, most of which had fewer than 40 beds. Forty-eight percent of hospital administrators in the study believed that the NPDB made it either somewhat or very much easier to reduce incompetent clinical practice at their facility. The study also found, however, that small rural hospitals were more satisfied with the NPDB and found it more useful than did larger hospitals. Only 3.1% of the hospitals in the study reported that a report from the NPDB directly affected a decision to deny or limit clinical privileges; zero percent of hospitals having 15 or more active medical staff indicated that adverse reports from the NPDB were instrumental

Not everyone, however, is as convinced of the data bank's usefulness. On January 31, 1995, in a memo entitled "National Practitioner Data Bank/Defense Practitioner Data Bank Status," Lieutenant Colonel David Litts of the Office of the Assistant Secretary of Defense/Health Administration, wrote:

"Since 1990, DoD [Department of Defense] made approximately 50,000 queries to the NPDB and had a match rate of about 1.5 percent. Correcting for redundant matches, this may represent as few as 250 bits of information at a cost of \$0.25M. Nationwide research by the NPDB has shown that forty percent of the time, Data Bank reports contained information already known by the querying entity. More significantly, though, Data Bank reports led hospitals to make privileging decisions they would not have otherwise made only one percent of the time."⁴³

While the central issue of Lieutenant Colonel Litts' memo was to determine realistic uses for and suggest modifications to the Defense Practitioner Data Bank (DPDB), his observations concerning the usefulness of its companion data bank (at least relative to its expense) are enlightening as to the role the NPDB plays in at least one Department's credentials

in their decision-making process, and overall, 43% of hospital administrators in the study believed that the cost exceeded the benefit to them).

⁴³ Memorandum from Lieutenant Colonel David Litts, Office of the Assistant Secretary of Defense (Health Affairs) (Jan. 31, 1995) (on file with author). According to the NPDB Help Line (1-800-767-6732), query fees are imposed on federal agencies, such as the Department of Defense, for NPDB queries; fees are not imposed on federal agencies for HIPDA queries.

decisions. In fact, the Colonel went on to say that "the effectiveness of the NPDB in the light of its tremendous cost should be further evaluated."⁴⁴

Colonel Litts is not alone in his opinion. The American Medical Association (AMA) would overwhelmingly concur and, in fact, their position has long been that the NPDB should be dissolved in its entirety.⁴⁵ The organization used last year's proposal to open the data bank to the public to reiterate this position, and at the same time voiced specific concerns regarding the data bank's contents and usefulness.

II. OPPOSITION TO PUBLIC ACCESS TO THE NPDB

Even before Representative Bliley had introduced his bill to Congress in September 2000, opponents aware of the upcoming proposal began voicing their objections. On March 1, 2000, Rodney Hochman, M.D., Chief Medical Officer and Senior Vice President of Sentara Healthcare in Norfolk, Virginia, testified before the House Commerce Committee's Subcommittee on Oversight and Investigations on behalf of the American Hospital Association (AHA).⁴⁶ During his testimony, he described the credentials process used by Sentara Hospitals and indicated that Sentara health care facilities queried the NPDB as required, but only used the information as a supplement to their own already comprehensive process.

⁴⁴ Litts, *supra* note 43. Because the NPDB is self-supporting, query fees fluctuate in order to ensure that costs are recovered from user fees. According to the NPDB Annual Report for 1999, current fees range from \$4-\$10 per practitioner name queried (the latter being the charge for self-query, per data bank). Thus, for those entities subject to mandatory queries, it is easy to see how the "cost per match" ratio, discussed *supra* at note 38, can represent a significant amount, particularly if the entity makes very few decisions based on the NPDB information provided.

⁴⁵ AMA Board of Trustees Report 31-I-00, *supra* note 7, at 9.

⁴⁶ Hochman, *supra* note 8.

According to Dr. Hochman, the AHA's arguments against opening the NPDB to the public are twofold, and overlap to a certain degree. First, public disclosure of the data bank's contents would undermine the confidentiality of the peer review process used to flesh out reports of medical errors which would ultimately impede the goal of promoting quality health care.⁴⁷ Secondly, the data bank, as currently configured, was not designed to be a consumer tool specifically because the bulk of its contents (malpractice payment reports) are prone to misinterpretation.⁴⁸ As the following discussion indicates, these concerns are, at least in part, meritorious.

A. Confidentiality of NPDB Contents

At the time the HCQIA was drafted in 1986, the House Committee on Energy and Commerce (now the Commerce Committee) emphasized that Congress did not design the NPDB to disseminate information to the public at large.⁴⁹ In discussing malpractice settlement data, for example, the Committee stated that "it is essential to collect and disseminate these data to those in the health care community who make judgments about the competence and professional conduct of health care practitioners [emphasis added]."⁵⁰ The report went on to say that the Committee was "confident that those authorized under this bill to gain access to this information will have the awareness and sensitivity to use it responsibly [emphasis added]."⁵¹

⁴⁷ *Id.*

⁴⁸ *Id.*

⁴⁹ H.R. Rep. No. 99-903, at § 207(b) (1986), reprinted in 1986 U.S.C.C.A.N. 6384, 6396.

⁵⁰ *Id.*

⁵¹ *Id.*

Clearly, the Committee recognized the difficulty that might ensue if a consumer attempted to interpret the data bank's physician-specific data in its raw form. As a result, information contained within the NPDB permitting identification of any particular practitioner, entity, or patient was made confidential when HHS designated the NPDB as a confidential system of records.⁵² The principle of confidentiality has thus governed the operation of the NPDB since its inception and has been integral to its operation.⁵³

The AHA promoted a second, related argument concerning confidentiality of data bank information and its effect on the relationship between quality of care and the peer review process used by health care providers. Although privileges and immunities have traditionally been a matter of state law, one of the basic initiatives of the HCQIA was the use of peer review to weed out bad physicians and other incompetent health care providers. In order to achieve that goal, the Act included provisions designed to encourage effective use of peer review by extending confidentiality to the peer review members' work product and immunity from private damages so long as peer review actions are conducted in good faith and in accordance with established standards.⁵⁴ The Act's implementing regulations also provided the necessary incentives to comply -- failure to do so could result in an entity losing its immunity for up to three years.⁵⁵

⁵² 42 U.S.C. § 11137.

⁵³ In a February 24, 2000 letter to the Chairman of the House Commerce Committee, HHS wrote, "The information collected in the data bank was never intended to serve as a complete history but rather as an important supplement to comprehensive and careful professional peer review of a practitioner's credentials. As a result, the statute puts in place confidentiality protections that create a strong expectation of privacy among the hundreds of hospital entities and insurance companies required to make regular and detailed submissions to the data bank."

⁵⁴ 42 U.S.C. § 11111.

⁵⁵ 45 C.F.R. § 60.9(c) (2000).

According to the AHA, opening the data bank would create significantly more tension among the various participants than already exists regarding reportable events. Allowing public access to adverse credentialing actions in the data bank would result in health care providers being less candid in revealing their own mistakes and those of their peers during the peer review process.⁵⁶ Ultimately, mistakes would be forced underground, thereby eliminating the opportunity to analyze them, how they occurred, and how to prevent them in the future. If the data bank's contents were publicly accessible, the real losers, say the AHA, would be the very same patients who are the intended beneficiaries of medically-related quality assurance efforts.

B. Medical Malpractice Payment Reports

Opponents to opening the data bank made an equally compelling argument in support of their position based on the specific contents of the NPDB. As was previously noted, nearly 80% of the NPDB's entries reflect malpractice payments made on behalf of health care practitioners.⁵⁷ Both the AMA and AHA claim that the typical consumer would be misled by the type of raw malpractice claims data contained in the NPDB. For example, there is no minimum threshold for reporting the amounts paid on malpractice claims, so even *diminimus* payments must be reported.⁵⁸ Furthermore, some states, though

⁵⁶ Hochman, *supra* note 8.

⁵⁷ Oddly, despite the high percentage of malpractice payment reports already made to the data bank, the number would likely be far higher if the corporate shield loophole, discussed *infra* at 33, was fixed.

⁵⁸ HRSA did not break medical malpractice payment reports down by actual dollar amounts in the NPDB Annual Report for 1999, making it difficult to pinpoint the number of "diminimus" reports actually submitted. According to Table 12 of the report, there were 15,142 payments reported in 1999 with a mean payment of \$226,739 and a median payment of \$108,675. These figures are fairly consistent with the cumulative totals. Adjusted for inflation, the

not all, limit the amount of malpractice awards, which means that payment reports from different states can vary widely even though they result from the same general type of claim.

The confusion surrounding interpretation of medical malpractice payment reports is compounded by the fact that the data bank does not differentiate between payments made in situations involving substandard care and those settled for what might be considered sound business reasons. The aggressiveness of the attorneys or the quality of evidence, such as medical records, may dictate that the best course of action is to settle the case, even though, in most circumstances, the payment is a reportable action.⁵⁹ Likewise, payments made for the purpose of eliminating defense of frivolous or non-meritorious claims or in order to minimize the costs of litigation must also be reported to the NPDB. In fact, many insurers disallow and some state laws prohibit "consent to settle" clauses, thus allowing the insurer to entirely disregard a practitioner's desire to defend himself or herself on the merits.⁶⁰

NPDB has a cumulative total of 133,505 payments, with an adjusted mean payment of \$213,335 and an adjusted median payment of \$100,000. Segregated out by categories, the lowest payment means and medians fell under "equipment or product related" and "miscellaneous." The remaining categories included monitoring, treatment, obstetrics, intravenous and blood products, medication, surgery, anesthesia, and diagnosis. Cf. Richard L. Granville, M.D. & Robert E. Oshel, *The National Practitioner Data Bank (NPDB) Public Use File: A Valuable Resource for Quality Assurance Personnel and Risk Managers*, Legal Med. 1998:1-6, 4 (indicating that between 1990-96, the NPDB had reports of 24,843 payments falling between \$0-10,000 representing 21% of all payments reported and 36% of all reported payments were \$25,000 or less. During the same timeframe, only 6% off all payments were over \$500,000). Legal Medicine is an annual publication put out by the Armed Forces Institute of Pathology, Department of Legal Medicine. Articles from the journal may be found at <http://www.afip.org/departments/legalmed/lmof.html>.

⁵⁹ Payments made out of a physician's own funds, or where a physician initially named in the claim has been removed from the settlement agreement are not reported to the data bank.

⁶⁰ Corlin, *supra* note 8.

Given all of these factors, a legitimate argument exists that without some type of contextual explanation, raw numbers of malpractice payment reports like those contained in the NPDB would be unhelpful, and perhaps even harmful, to the public. During an interview on the evening news program, "Nightline," Richard Corlin, M.D., then President-Elect of the AMA, stated that consumers have a right to what he called "properly expressed" malpractice information.⁶¹ If given only numbers and amounts of malpractice payments made on behalf of a practitioner, the average consumer might conclude that the numbers are an effective barometer of physician competence and decide against using what might be a very well-qualified doctor.

The use of explanatory provisions to put physician-specific information in context was a common theme throughout the debate on public accessibility to the NPDB. Consumers should know, for example, that certain specialties are prone to greater risk than others and that those who deal with high-risk patients or perform state-of-the-art procedures are far more likely to attract litigation just by the very nature of their practice.⁶² Likewise, the longer a physician is in practice, the greater the likelihood that he will have been exposed to a malpractice claim.⁶³

Those who oppose public access to the NPDB insist that the data bank must control for such contextual variations before it can be useful as a consumer tool. Interestingly, Representative Bliley's proposal, which was modeled after the State of Massachusetts' publicly-accessible data bank,⁶⁴

⁶¹ *Nightline* (ABC television broadcast, (Sep. 20, 2000) (transcript on file with author)).

⁶² Dingell, *supra* note 11. For example, obstetrics and neurosurgery generally top the list of "high-risk" medical specialties.

⁶³ *Id.*

⁶⁴ Massachusetts' Physician's Profiles Program can be accessed through a toll free call, 1-800-377-0550, or via their web site, <http://massmedboard.org> (last visited Apr. 1, 2001).

called for the very kind of contextual information that opponents of the bill said was needed. For example, the bill required:

- comparisons between the physician involved and the experiences and payments made on behalf of other physicians in the same specialty;⁶⁵
- disclosure of whether the amount paid was in settlement, or partial settlement of or in satisfaction of a judgment in a medical malpractice action or claim;⁶⁶
- a statement that payment made pursuant to a malpractice claim may be made for a variety of reasons and that physicians who work with high-risk patients may have higher numbers of medical malpractice claims against them;⁶⁷ and,
- a statement that malpractice histories differ by specialty and as a result of variances in state law and the data bank's information compares physicians based on those factors.⁶⁸

Finally, Representative Bliley's proposal required a statement that a payment should not be construed as creating a presumption that medical malpractice occurred and is not necessarily reflective of a practitioner's competence.⁶⁹

⁶⁵ H.R. 5122 § 428(e)(1)(A) (2000).

⁶⁶ *Id.* § 428(e)(1)(B)(ii).

⁶⁷ *Id.* § 428(e)(4).

⁶⁸ *Id.* § 428(e)(5) and (6).

⁶⁹ *Id.* § 428(e)(2) and (3).

Credible data supports the theory that there is a weak correlation between medical malpractice claims/payments and negligence. In 1991, a group of researchers published the results of the Harvard Medical Practice Study in the New England Journal of Medicine.⁷⁰ The study centered on adverse events involving more than 30,000 randomly selected discharges from 51 randomly selected New York hospitals during 1984.⁷¹ The findings of the study, which were later corroborated by a study of adverse events in Colorado and Utah in 1992,⁷² indicated that medical malpractice claims are rarely made after patients are injured negligently and, conversely, that claims are relatively frequent even in the absence of negligent injury.⁷³

Because the researchers involved in the Harvard Medical Practice Study lacked information on the eventual outcome of the cases studied, they were unable to evaluate the overall ability of medical malpractice litigation to make accurate determinations and decided to conduct a 10 year follow-up of the malpractice claims identified in the original study.⁷⁴ For definitional purposes, "accurate determinations" meant that only meritorious claims resulted in compensation and that non-meritorious claims resulted in no compensation.⁷⁵ In the 51 litigated claims identified for follow-up, they discovered that the severity of the patient's disability, not the occurrence of an adverse event or an adverse event due to negligence, was predictive of

⁷⁰ A. R. Localio et al., *Relation Between Malpractice Claims and Adverse Events due to Negligence: Results of the Harvard Medical Practice Study III.* 325 N. Eng. J. Med. 245, 245-251 (Jul. 25, 1991).

⁷¹ *Id.*; "adverse event" is defined as an injury caused by medical management rather than by the underlying disease or condition of the patient. Some adverse events are attributable to errors, others to negligence.

⁷² Eric J. Thomas, M.D. et al., *Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado.* 38 Med Care 261, 261-271 (Spring, 2000). Adverse events due to negligence was 27.6% and 29.2% in the New York and Colorado/Utah studies, respectively.

⁷³ Localio, *supra* note 70.

⁷⁴ Troyen A. Brennan et. al., *Relation Between Negligent Adverse Events and the Outcomes of Medical-Malpractice Litigation,* 335 New Eng. J. Med. 1963, 1963-67 (Dec. 26, 1996).

the payment to a patient.⁷⁶ Researchers admitted that the follow-up study had limitations which prevented them from providing generalized insight, but nevertheless concluded that the results suggested that the standard of medical negligence does not correlate well to malpractice litigation, further bolstering the arguments against opening medical malpractice payment information to the public.⁷⁷

Similarly, in 1994, the Armed Forces Institute of Pathology published the results of its study into the relationship of malpractice payments to the occurrence of substandard care using the DoD's database of closed malpractice claims in an attempt to show the effect that reporting thresholds might have on the NPDB.⁷⁸ The study, which will be more fully discussed in the next section, concluded that malpractice claim payments and payment amounts correlated poorly with standard of care determinations and that the "fairness" of reporting payments does not significantly improve by imposing arbitrary reporting thresholds.⁷⁹

⁷⁵ *Id.* at 1963.

⁷⁶ *Id.* Among the 51 cases, 10 of 24 originally identified as having no adverse event settled for the plaintiffs with a mean payment of \$28,760. Six of 13 involving adverse events but no negligence settled for the plaintiffs with a mean payment of \$98,192, and in 5 of 9 cases in which adverse events due to negligence were found, the settlement mean was \$66,944. Seven of eight claims involving permanent disability were settled with a mean payment of \$201,250.

⁷⁷ *Id.* at 1967. The limitations identified were that the study had a relatively small number of cases and those cases only reflected litigation practices in New York.

⁷⁸ Richard L. Granville, M.D., & Stephen V. Mawn, Commander, Medical Corps, U.S. Naval Reserve, *A Threshold Question: How do Payment Amounts in Medical Malpractice Claims Relate to the Medical Care Rendered?*, 1994:1-6.

**C. Using the Department of Defense Model as an Alternative Medical
Malpractice Reporting Process**

The reporting process used by the Department of Defense (DoD) has both been applauded by the AMA as a method which recognizes the problem with trying to correlate lawsuits with physician competence or negligence and criticized by HRSA as a variant of the corporate shield (discussed infra).⁸⁰ As earlier stated, the mandatory reporting provisions of the HCQIA were inapplicable to the federal government, but the Act required HHS to enter into memoranda of understanding (MOU) with certain federal agencies so as not to create incentives for physicians identified under the program to move undetected from the federal to the civilian sector or vice versa.⁸¹

On September 21, 1987, the Departments of Defense and Health and Human Services entered into a MOU in accordance with the directive of the HCQIA.⁸² The MOU outlines reporting requirements for professional sanctions (clinical privileging actions) and practitioner misconduct which are similar to their civilian counterparts' reporting requirements, but the provision pertaining to malpractice reports requires a peer review process unavailable in the civilian sector. According to DoD policy, "...all malpractice claims shall be analyzed by peer review, assigned a category of responsibility, and reported as follows..."⁸³ The three enumerated categories are:

⁷⁹ *Id.* at 5.

⁸⁰ NATIONAL PRACTITIONER DATA BANK, 1999 ANNUAL REPORT, *supra* note 22, at 18; Corlin, *supra* note 8; see also AMA Board of Trustees Report, *supra* note 7, at 4 (indicating that DoD representatives told the AMA that the correlation of settled claims and actual negligence is about 30%).

⁸¹ Act of November 14, 1986, Pub. L. N. 99-660, § 302, 1986 U.S.C.C.A.N. (99 Stat.) 6384, 6404-5.

⁸² *Id.*

⁸³ Memorandum of Understanding between the Department of Health and Human Services and the Department of Defense, Sept. 21, 1987.

- o Standard medical care. Payments made for claims in which the patient was found to have received appropriate care shall be reported under the name of the primary physician.
- o Minor deviation from standards of care. When payments are made for claims in which the patient was found to have received care that was substandard in minor respects, a separate report shall be submitted for each practitioner found to have provided substandard care.
- o Major deviation from standards of care. When payments are made for claims in which the patient was found to have received care that was substandard in major respects, a separate report shall be submitted for each practitioner found to have provided substandard care.⁸⁴

The DoD's participation in the NPDB was officially implemented through publication of a directive on November 1, 1990 and was subsequently published in the Federal Register on December 6, 1990.⁸⁵ Among other things, the regulation states that DoD policy requires quality assurance review in every case involving a potential instance of malpractice by a DoD practitioner and makes the Assistant Secretary of Defense (Health Affairs) responsible for issuing any necessary DoD instructions to provide further guidance.⁸⁶

⁸⁴ *Id.*

⁸⁵ Department of Defense Participation in the National Practitioner Data Bank, 55 Fed. Reg. 50,321 (Dec. 6, 1990) (codified at 32 C.F.R. pt. 221). Department of Defense implementing regulations are found in DoD Directive 6025.14, "Department of Defense Participation in the National Practitioner Data Bank (NPDB)," Nov. 1, 1990.

⁸⁶ *Id.* Citations to some of the DoD directives and instructions appear at footnotes 80 and 83. Often, these directives further delegate responsibility within each military service to, for example, the Secretary of the Navy (see *infra* footnote 132), who further delegates to the Bureau of Medicine and Surgery (BUMED). Pertinent instructions concerning the implementation of and process for reporting within the United States Navy include BUMED Instruction 6010.18, "Participation in the National Practitioner Data Bank (NPDB)," May

Finally, it charged the various Secretaries of the Military Departments with implementation of the regulatory requirements.⁸⁷

Within the DoD, the statute of limitations requires that a claimant, or his attorney, file a claim within two years of the act giving rise to the action with the local office of the Staff Judge Advocate. The claim is forwarded to the cognizant military claims service office as necessary (Navy, Air Force, or Army) for initial action. The claims office has six months during which to settle or deny the claim. If the claim is denied, the claimant may file suit in U.S. District Court and any case thus filed will be managed by a U.S. Attorney from the Department of Justice (DOJ).⁸⁸

All medical malpractice payments within the DoD are presumed to be made for the benefit of a healthcare practitioner.⁸⁹ This presumption is conclusive 180 days after the Surgeon General of the military department involved (i.e., Navy, Army, or Air Force) receives notice of the payment unless, prior to that date, the Surgeon General makes a final determination that the malpractice payment was not caused by the failure of any practitioner(s) significantly involved to meet the standard of care.⁹⁰

18, 1993 and BUMED Instruction 6320.67A, "Adverse Privileging Actions, Peer Review Panel Procedures, and Health Care Provider Reporting," Dec. 30, 1998.

⁸⁷ *Id.*

⁸⁸ Within the Department of the Navy, the settlement limitations are \$50,000 and \$200,000 for the Commanding Officer, Naval Legal Service Office (the "claims" office) and the Judge Advocate General Headquarters, Civil Law Division (Claims, Investigations, & Tort Litigation), respectively.

⁸⁹ DoD Instruction 6025.15, "Implementation of Department of Defense Participation in the National Practitioner Data Bank (NPDB)," Oct. 12, 2000. Based on this clear language and the process used for reporting DoD practitioners, one can assume that in those cases where negligence is clearly due to circumstances not attributable to the practitioner, as in the case of faulty equipment, for example, the final determination can be reached far more quickly than it otherwise might.

⁹⁰ *Id.*

The process followed by the Surgeon General in making a final determination is fairly complex. Based on the results of the initial quality assurance review, the Surgeon General makes a preliminary determination on whether the malpractice payment was or was not caused by the failure of one or more practitioners to meet the standard of care. If his determination is that the payment was not caused by a failure to meet the standard of care, the entire case file is forwarded for external peer review.⁹¹ The external peer reviewer provides the Surgeon General with an opinion as to whether or not the standard of care was met for each involved provider.⁹²

The Surgeon General makes his final determination following receipt of the external peer review opinion. If the final determination is that the malpractice payment was not caused by failure to meet the standard of care, the presumption (that malpractice payments are made for the benefit of a healthcare practitioner in all cases) is overcome and no report is made to the NPDB.⁹³ If the converse is found or the 180 day period runs before the Surgeon General has made his final determination, a report is made in the name of any and all significantly involved practitioners.⁹⁴ Although this report can later be amended by the Surgeon General's office if the entry was due to a lapse of the 180 day clock, it may not be removed from the NPDB, even if the eventual determination is that the standard of care was not breached.⁹⁵

⁹¹ *Id.* Such external review will also take place in those situations where a system problem is identified rather than failure to meet the standard of care.

⁹² *Id.* External peer reviews are designated confidential quality assurance records under 10 U.S.C. § 1102.

⁹³ *Id.*

⁹⁴ *Id.*

⁹⁵ *Id.*

It should be noted, however, that there are many payments made under various military compensation programs that result from medical care rendered but which are not malpractice payments under NPDB rules. The Supreme Court decision in Feres v. United States, 340 U.S. 135 (1950) provided that because of the unique nature of military service, military members killed or injured incident to military service must rely on the military disability system and other military compensation programs as their exclusive remedies. Thus, Federal court jurisdiction is not available under the Federal Tort Claims Act for those injured "incident to service." Recognizing the reporting discrepancies this might cause,⁹⁶ the DoD requires that such cases be reviewed using a process similar to that used for NPDB reporting. If the final determination is that a report should be made, the reporting information is forwarded to the Defense Practitioner Data Bank (DPDB), a separate DoD database maintained by the Armed Forces Institute of Pathology, Department of Legal Medicine.⁹⁷

"Tort-2," a part of the DPDB, is a risk management database which contains entries on all closed DoD malpractice claims since 1988, both paid and unpaid.⁹⁸ Obviously then, with regard to DoD malpractice claims, Tort-2 is far more inclusive in its entries than the NPDB. As of mid-1998, Tort-2 had 4,164 entries (as compared to a total of 4,580 in the DPDB), 1,661 of

⁹⁶ See *infra*, note 97 and accompanying text. For example, the annual number of DoD malpractice claims filed is approximately 1,000 or 7 to 9 claims per 100 physicians. The annual rate of claims filed per 100 civilian sector physicians is approximately 12 to 16. Given that DoD has an active duty patient population of approximately 20%, without the application of the Feres Doctrine, the DoD annual rate of claims would no doubt increase.

⁹⁷ DoD Instruction 6025.15, *supra* note 89. The Defense Practitioner Data Bank (DPDB) is a software program used since 1982 and modified twice (1988 and 1990) to track malpractice claims and adverse privileging actions throughout DoD.

⁹⁸ Richard L. Granville, M.D. et al, *Characteristics of Department of Defense Medical Malpractice Claims: A Quality Management Tool*, 1999:1-8, 1. A claim is considered "closed" when final legal action has been taken.

which had been paid.⁹⁹ Available statistics indicate that the Surgeon General determined that the standard of care had been met in 68.9% of Tort-2 cases, had not been met in 25.5% of cases, and another 5.6% were undetermined.¹⁰⁰ Of the paid cases in the DPDB, 18.3% of the cases resulted in payments of \$10,000 or less and a total of over 40% resulted in payments of under \$25,000.¹⁰¹ At the other end of the spectrum, nearly 10% of claims paid resulted in payments in excess of \$500,000.¹⁰²

Recently, HRSA officials expressed concerns about the limited quantity and timeliness of reports they receive following DoD peer review processes leading one to believe that HHS is skeptical about the efficacy and efficiency of the process.¹⁰³ On the other hand, HRSA is entertaining a proposal that would permit peer review organizations to determine which practitioners involved in malpractice settlements should be reported to NPDB, thereby lending a certain validity to the process used by DoD and the notion that it presents more accurate reporting results.

The "fairness" of the DoD's reporting process has not been a specific focus of scholarly articles, however, in 1994, the Armed Forces Institute of Pathology (AFIP) published an article which explored the effect that reporting thresholds might have on the NPDB.¹⁰⁴ The study, based on Tort-2 statistics, was unique in that each case within the database had already been subject to several levels of scrutiny in order to determine whether the standard of care had been met. The author made various comparisons involving

⁹⁹ *Id.*

¹⁰⁰ *Id.* at 5. An indeterminate evaluation is generally the result of inadequate medical records for review.

¹⁰¹ *Id.* at 7. Similar statistics regarding the NPDB entries may be found at note 58.

¹⁰² *Id.*

¹⁰³ GENERAL ACCOUNTING OFFICE REPORT, GAO-01-130, *supra* note 28, at 12.

¹⁰⁴ Granville, *supra* note 78.

the standard of care determinations (remember, this database contains all closed DoD malpractice claims, not just those reported to the NPDB), paid and unpaid cases, and, in the case of the former, amounts paid.¹⁰⁵ He then imposed arbitrary reporting thresholds of \$25,000, \$30,000, and \$50,000 and concluded that although such thresholds would prevent many cases in which the standard of care was met from being reported to the NPDB, it would also dramatically decrease the number of reports of cases arising from substandard care.¹⁰⁶ Thus, the author concluded that the "fairness" of reporting payments was not significantly improved by using payment thresholds.¹⁰⁷

More importantly, the AFIP article provided a useful comparison of Tort-2 cases based on standard of care determinations and payment status from which one can make certain assumptions regarding the fairness of the DoD reporting process. As of 1994, when the article was written, the Tort-2 database contained 1,750 cases in which senior reviewers had already made standard of care determinations.¹⁰⁸ Of the 713 cases resulting in payment, the standard of care had been met in 55% of them.¹⁰⁹ Of the 1,037 unpaid cases, the standard of care was met in over 83% of the case, but was not met in 16% of them.¹¹⁰

In the civilian sector, all 713 paid cases would have been reported to the NPDB as compared to approximately 321 (paid/standard of care not met)

¹⁰⁵ *Id.*

¹⁰⁶ *Id.* at 3. For example, using DoD statistics, the author found that with a \$50,000 threshold, nearly 4 out of 10 paid cases represented situations where reviewers had determined that the standard of care had been met. Conversely, he found that over 63% of cases in which the standard of care was not met would go unreported at the \$50,000 threshold.

¹⁰⁷ *Id.* at 5.

¹⁰⁸ *Id.* at 2. Tort-2 contained 1,932 cases at the time, but standard of care determinations were "indeterminate" in nearly 200 of them resulting in their exclusion from this study.

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

within the DoD. In other words, were it not for the DoD process, another 392 DoD cases would have been reported to the NPDB despite the standard of care having been met. On the other hand, the actual number of unpaid cases involving substandard care seems quite low, given the fact that, as the author noted, the 16% includes cases in which there was no compensable injury, cases in which the substandard care was not the cause of the claimant's injury, and those involving procedural flaws, such as statute of limitations issues.¹¹¹

III. ADDITIONAL DEFICIENCIES PLAGUE THE NPDB

A. The GAO Report: Inaccurate, Incomplete, and Untimely

In November 2000, the General Accounting Office's (GAO) Letter Report entitled, "National Practitioner Data Bank: Major Improvements Are Needed to Enhance Data Bank's Reliability," delivered a major blow to those in support of allowing public access to the data bank.¹¹² Two of the three areas reviewed by the GAO are pertinent to this report: (1) evaluation of the accuracy, completeness, and timeliness of reported data; and (2) assessment of HRSA's efforts to address underreporting.¹¹³

After interviewing representatives of HRSA, HHS/OIG, and various other health care industry organizations, and reviewing HRSA's operational and research plans, studies, and other documentation (including reports submitted during the test month of September 1999), the GAO concluded: "NPDB

¹¹¹ *Id.*

¹¹² See generally GENERAL ACCOUNTING OFFICE REPORT, GAO-01-130, *supra* note 28.

¹¹³ *Id.* The third problem identified in the GAO report concerned assessment of internal controls over user fees and expenditures.

information may not be as accurate, complete, or as timely as it should be. Inaccuracies in the way reported information was coded could confuse or mislead querying organizations about the severity of actions taken against practitioners.¹¹⁴ The true significance of this statement lies not so much in what was said as what was not - - that if querying organizations with guidebooks¹¹⁵ to lead them through the reports could be confused by them, what real chance does the average consumer have of making sense of the data bank's contents?

The GAO outlined some of the major contributing factors to the NPDB's failures regarding accuracy, completeness, and timeliness. Not only did the reviewers discover that duplicate reports overstate and may in fact double the amount of information the NPDB has on any particular practitioner, but they also found that the processes established for correcting erroneous submissions and/or duplications have failed.¹¹⁶ They noted inaccuracies in all three of the types of reports under review. In general, medical malpractice reports were incomplete with over 95% of them failing to indicate what role the standard of care played in making a settlement or award determination.¹¹⁷ Approximately one-third of adverse clinical privileges reports reviewed were inaccurate,¹¹⁸ and eleven percent of state licensure actions contained misleading or inaccurate information on the level of discipline given or the actual number of times a practitioner was subjected to discipline.¹¹⁹

¹¹⁴ GENERAL ACCOUNTING OFFICE REPORT, GAO-01-130, *supra* note 28, at summary.

¹¹⁵ See generally Department of Health and Human Services, Health Resources and Services Administration, *National Practitioner Data Bank Guidebook* (May 1996). An updated Guidebook, scheduled for completion in the Fall 2000, was unavailable at the time of this writing.

¹¹⁶ GENERAL ACCOUNTING OFFICE REPORT, GAO-01-130, *supra* note 28, at summary. The two methods for correcting erroneous reports are practitioner notification and dispute resolution.

¹¹⁷ *Id.* at 5.

¹¹⁸ *Id.*

¹¹⁹ *Id.*

The GAO's detailed dissection of sample reports provided further illumination of the specific deficiencies noted during the review. For the sample month of September 1999, 250 out of 1,300 malpractice reports were reviewed and only 1 out of those 250 met NPDB reporting requirements.¹²⁰ While some of the requirements are descriptive of the patient, others relate to the quality of practitioner performance -- the very type of information which helps queriers identify performance problems. Of the 5% of malpractice reports whose narrative section indicated that standard of care had been considered, only one report noted the actual determination.¹²¹

Data bank licensure reports and clinical privilege restriction reports were likewise flawed. Twenty-four of the 252 licensure reports submitted during September 1999 contained inaccurate characterization of actions and considerable variation in the amount and type of narrative information provided.¹²² The lack of narrative information further frustrated the reviewers as they tried to discern whether seemingly duplicate reports were, in fact, just that.¹²³ Similar to the findings regarding licensure reports, mischaracterization of actions taken made up the bulk of inaccuracies for clinical privilege restriction reports, though the GAO report indicated that overall, the latter's narrative sections proved of far greater help than those in the licensure reports.¹²⁴

¹²⁰ *Id.* at 20.

¹²¹ *Id.* at 21.

¹²² *Id.* at 22. According to the report, this may be due in part to HRSA's lack of established criteria for information which should be included in the narrative sections of both clinical privilege restriction reports and licensure reports.

¹²³ For example, some practitioners were reported for licensure actions twice during the month of September 1999. Without adequate narratives, the reviewers could not tell if the licensure action was reported twice for the same event.

¹²⁴ GENERAL ACCOUNTING OFFICE REPORT, GAO-01-130, *supra* note 28, at 24.

HRSA responded to the GAO's concern regarding inaccuracies by stating that only in cases of obvious error do staffers request corrected reports and that contract staff charged with inputting data bank information are not authorized to make any changes to submissions.¹²⁵ Although HHS concurred with a GAO recommendation to improve compliance monitoring and enforcement and to develop criteria for descriptive information to be included in disciplinary action reports, the Department did not concur with a specific recommendation aimed at improving the reliability of reported information.¹²⁶

B. NPDB Annual Report 1999

Although the GAO report provides a more recent outline of some of the factors contributing to the NPDB's unreliability, it would be misleading to presume that the data bank's administrators did not already recognize some of its own problems. Each year the data bank publishes an annual report which highlights a variety of areas pertinent to its operation. The report contains statistical data (both annual and comprehensive), the status of current projects, the results of ongoing and completed projects, and information concerning problems and the proposals which have been or are being considered to remedy those problems.

Two of the problems discussed in the National Practitioner Data Bank's Annual Report for 1999 (the most recent report available at the time of this writing) directly relate to the debate which followed Representative Bliley's proposal to make the data bank accessible to the public. Both concern

¹²⁵ *Id.* at 21.

¹²⁶ *Id.* at 6. Specifically, GAO recommended that HRSA develop procedures to routinely check the accuracy and completeness of information, to obtain

underreporting; the first is of medical malpractice payments due to use of the "corporate shield" (which may seem surprising given that such payments make up the bulk of the data bank's contents), and the second concerns clinical privileging actions.

1. The Corporate Shield Loophole

Despite the high percentage of entries for malpractice payment reports, there is a loophole within the NPDB's implementing regulations that could represent a significant amount of underreporting of malpractice payments. Under current regulations, a licensed practitioner must be named in two documents in order to trigger the NPDB's reporting requirement: (1) a written complaint or claim, and (2) the release of the claim.¹²⁷ Corporate entities, such as hospitals and professional corporations, are not reported. The situations under scrutiny are those in which plaintiffs in malpractice actions dismiss an individual defendant just prior to settlement, and leave or substitute a nonreportable entity, such as a hospital or professional corporation.¹²⁸ This practice is known as using the "corporate shield."

HRSA officials have not been able to quantify the extent to which the loophole is used for this purpose, but assert that it compromises the usefulness of the NPDB as a flagging system when a practitioner who has

corrections from reporters when necessary, user and practitioner notifications procedures.

¹²⁷ 45 C.F.R. § 60.7 (2000).

¹²⁸ McDermott, Will, & Emery, *National Practitioner Data Bank Proposes Controversial Expansion of Reporting Requirements*, 16 Health Law Update 5, (Apr. 13, 1999), at <http://www.mwe.com/news/hlu1605.htm>. In the article, the AHA reportedly stated that statistics from one of its state hospital association members indicated that in 1997, approximately 97% of malpractice lawsuits settled prior to trial with no admission of wrongdoing by any party and without the names of any licensed practitioners.

committed malpractice is able to avoid being reported in this way.¹²⁹ In an effort to close the loophole, in December 1998 HHS introduced a Notice of Proposed Rulemaking.¹³⁰ In the preamble to the proposal, HRSA stated that the payer, during the course of its review of the claim, would be required to identify any practitioner whose professional conduct was at issue.¹³¹ Specifically, the change would have required any entity making a payment to name the practitioner(s) regardless of whether he or she was actually named in the original claim or the release if, in the payer's opinion the practitioner(s) contributed to the alleged malpractice.¹³²

Not surprisingly, the proposal met with swift opposition from the health care field, including the AHA, AMA, and the American Insurance Association. In a somewhat revealing statement as to the possible extent to which the corporate shield is used, a representative of the AMA commented, "It is not the government's duty to second guess the plaintiff who has the benefit of the discovery process...in finding potentially culpable parties."¹³³ They also argued, and the American Insurance Association (AIA) agreed, that the change would increase litigation (since practitioners would likely contest any settlement attempts) resulting in even higher malpractice coverage costs for practitioners. The insurance industry further argued that the requirement would interfere with settlement negotiations, placing malpractice insurers in the role of investigator, judge, and jury in malpractice claims. According to the AIA, the insurer would be unprotected if he reported improperly, and practitioners would be denied due process in

¹²⁹ NATIONAL PRACTITIONER DATA BANK, 1999 ANNUAL REPORT, *supra* note 22, at 18.

¹³⁰ National Practitioner Data Bank for Adverse Information on Physicians and Other Health Care Practitioners: Medical Malpractice Payments Reporting Requirements, 63 Fed. Reg. 71,255 (Dec. 24, 1998).

¹³¹ *Id.*

¹³² *Id.*

¹³³ McDermott, *supra* note 128.

those cases where they are initially named in a lawsuit, but later found not liable by the court.¹³⁴

In response to the volumes of comments opposing the changes, HRSA withdrew the proposal, but indicated that the Department would continue to explore other methods to resolve the underreporting which the corporate shield loophole permits.¹³⁵ HRSA has been working closely with the NPDB Executive Committee, which opposed the proposed changes, in an effort to come up with a proposal reasonable to all concerned.¹³⁶ Full support of this powerful Committee is essential if HHS hopes to make any change to medical malpractice reporting requirements.

2. Underreporting of Hospital Privileging Actions

Hospital credentialing committees and malpractice litigation have long been two of the major quality assurance measures in health care. Over the past two and a half decades, the latter has been the more influential of the two.¹³⁷ This influence seems to have had a tendency to degrade, rather than improve, the quality of care.

¹³⁴ GENERAL ACCOUNTING OFFICE REPORT, GAO-01-130, *supra* note 28, at 11.

¹³⁵ *Id.* In a telephone interview with Mark Pinchus, HRSA, Quality Assurance Division (Apr. 17, 2001), Mr. Pinchus stated that his division continues to work with industry representatives and that they are considering "a regulatory approach" to resolving the problem. Because such an approach would require Congressional action, the recent change in administration has, at least for the time being, stymied progress. Mr. Pinchus also stated that he is unaware of any plan by a Congressional representative to introduce such regulatory measures during the current session.

¹³⁶ The Committee has been in existence since 1988 and its membership includes health care representatives from accrediting bodies, licensing boards, hospitals and other health care providers, malpractice insurers, and professional societies.

¹³⁷ Troyen A. Brennan, *Hospital Peer Review and Clinical Privileges Actions: To Report or Not Report*, 282 JAMA 384 (Jul. 28, 1999).

In a mid-year broadcast of Nightline, then AMA President-elect Richard Corlin, stated, "The American Medical Association is very concerned that the public be able to get access to data concerning licensing problems, disciplining, and valid malpractice information on any physician that they're going to [sic][emphasis added]."¹³⁸ The recent GAO report also addressed this issue, stating that health care industry representatives agree that disciplinary actions taken by health care providers and states are better indicators of professional competence than malpractice reports.¹³⁹

Nevertheless, because restriction or loss of a physician's hospital privileges is such a serious action, hospitals will generally only suspend those privileges as a last resort. In a 1994 study of 149 rural hospitals, the most frequently reported changes to hospital quality assurance activities since the NPDB began collecting data concerned increased usage of alternatives to restricting clinical privileges.¹⁴⁰ More and more, hospitals and other healthcare entities opt for less onerous, non-reportable actions such as professional supervision, additional medical education, and short-term privilege restrictions.¹⁴¹ Thus, the very immunity that the HCQIA of 1986 provided to peer review activities in order to bolster self-regulation may in fact have a negative effect on improving the quality of care, the legislated purpose of the NPDB.

¹³⁸ *Nightline*, *supra* note 61.

¹³⁹ GENERAL ACCOUNTING OFFICE REPORT, GAO-01-130, *supra* note 28, at 4.

¹⁴⁰ Neighbor, *supra* note 42, at 665. Thirteen percent of the study hospitals reported increases in monitoring professional activities without restricting clinical privileges, 12% reported increases in the use of continuing medical education without restricting clinical privileges, 7% reported increases in having physicians resign or voluntarily surrender clinical privileges, and 5% reported increases in imposing disciplinary periods shorter than 31 days.

¹⁴¹ Brennan, *supra* note 137, at 385. Short-term refers to periods of 30 days or less.

The actual number of reports of disciplinary actions taken by health care providers have led to serious concerns of underreporting of such actions. Despite pre-operational predictions ranging from 5,000 (Public Health Service) to 10,000 (AMA) clinical privileging reports annually, the NPDB had received a total of fewer than 9,000 after nine years of operation.¹⁴² As of December 31, 1999, 59.5% of non-Federal hospitals registered with the NPDB and in an active status had never reported a clinical privileges action to the NPDB.¹⁴³ Asked by HRSA management in 1995 to study the perceived underreporting of clinical privilege restrictions, the Department of Health and Human Services' Office of Inspector General (HHS/OIG) found that approximately 75% of all hospitals had not reported a single privileging action to the NPDB during the three year period studied. HHS/OIG concluded that the issue demanded further attention by HRSA, and suggested that HRSA refocus the energy it was expending on underreporting of malpractice payments to underreporting of clinical privileges actions.¹⁴⁴

In addition to the HHS/OIG study, a second study of 4,743 short-term, nonfederal, general medical/surgical hospitals throughout the United States between 1991 and 1995 concluded that there is a low and declining level of hospital privileges actions reported to the NPDB.¹⁴⁵ According to the study, more than 65% of the study hospitals, including more than 250 large hospitals (those with 300 or more beds), reported no privileging actions during the 5

¹⁴² GENERAL ACCOUNTING OFFICE REPORT, GAO-01-130, *supra* note 28, at 13.

¹⁴³ NATIONAL PRACTITIONER DATA BANK, 1999 ANNUAL REPORT, *supra* note 22, at 22. The report goes on to say that clinical privileges reporting seems to be concentrated in a few facilities and that the pattern may reflect a hospital's unwillingness to take reportable actions more than it reflects a concentration of problem physicians in a few hospitals.

¹⁴⁴ GENERAL ACCOUNTING OFFICE REPORT, GAO-01-130, *supra* note 28, at 13.

¹⁴⁵ Laura-Mae Baldwin et al., *Hospital Peer Review and the National Practitioner Data Bank: Clinical Privileges Action Reports*, 282 JAMA 349 (Jul. 28, 1999).

years under study.¹⁴⁶ The study's conclusion suggested that the NPDB is a disincentive to effective peer review, pointing to fear of liability and preexisting personal and professional ties between the peer reviewers and their colleagues under review as barriers to its success.¹⁴⁷

Although HRSA has not embarked on any definitive course of action to remedy the perceived low level of reported clinical privilege actions, the Administration did develop a model state adverse action reporting statute and model state regulations to address the issue.¹⁴⁸ One suggested remedy to combat underreporting is to give HRSA the authority to penalize organizations for failure to report disciplinary actions similar to the penalty authority currently available for failure to report malpractice payments.¹⁴⁹ HHS/OIG recommended seeking such authority for HRSA and, in fact, in June 2000 HRSA asked HHS to pursue legislation which would allow them to fine health care providers up to \$25,000 for noncompliance.¹⁵⁰ As HRSA pointed out, however, penalty authority alone will not suffice because HRSA also lacks the authority to gain access to confidential peer review records maintained by hospitals and other health care providers on practitioner performance.¹⁵¹ Without such access (not to mention a skilled investigatory staff), they cannot ferret out noncompliant organizations, a necessary prerequisite to the imposition of fines.

¹⁴⁶ *Id.* at 351.

¹⁴⁷ *Id.* at 354.

¹⁴⁸ NATIONAL PRACTITIONER DATA BANK, 1999 ANNUAL REPORT, *supra* note 22, at vii.

¹⁴⁹ GENERAL ACCOUNTING OFFICE REPORT, GAO-01-130, *supra* note 28, at 13.

¹⁵⁰ *Id.* at 14.

¹⁵¹ *Id.*

**IV. POSSIBLE ALTERNATIVE SOURCES OF PUBLICLY ACCESSIBLE PHYSICIAN
PERFORMANCE INFORMATION**

Fortunately or not, the abundant and widely reported problems which plague the NPDB seem to have vindicated those who opposed public access even if they were perhaps originally motivated by a more simple, somewhat selfish concept: protection of one's own. Following publication of the findings of the GAO study, an editorial comment in AMNews read: "[W]idespread availability of [balanced and complete information about physicians] will effectively silence much of the political clamoring for opening access to the National Practitioner Data Bank to the public, and over time may make the inefficient and ill-conceived federal data bank irrelevant."¹⁵²

The AMA and AHA say that the NPDB's malpractice numbers would be misleading, and that clinical privileging and disciplinary actions would be better indicators of physician incompetence, but as previously discussed, there is strong reason to believe that the latter is considerably underreported to the NPDB. Undoubtedly, this could be equally misleading to consumers. The NPDB may have fallen far short of the ideal of providing accurate, useful information relative to a physician's competence to practice, but the demand for public access to physician-specific performance information remains. The question is, what resource can provide it?

Two potential alternate sources for publicly available physician performance information were repeatedly mentioned during the ongoing debate over Representative Bliley's proposal: state physician profiling systems and the Federation of State Medical Boards (FSMB). States have historically

¹⁵² Editorial, GAO Reports What Physicians Know: National Practitioner

collected data on their licensees and with the growing popularity of the Internet, many have undertaken either mandatory or voluntary initiatives for physician profiling over the past several years. The FSMB, on the other hand, is a private sector organization which has been collecting data from the various state medical boards for nearly 40 years. Both were espoused as potential sources of the type of "balanced and complete" physician information that the public needs, but as will be discussed in the following paragraphs, the AMA seems to have lost some of the enthusiasm with which they once embraced the notion of public access to the contents of the FSMB.¹⁵³

A. The Federation of State Medical Boards

The Federation of State Medical Boards began in 1912 and its membership is comprised of the medical boards of the United States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, and 13 state boards of osteopathic medicine.¹⁵⁴ The Federation is the parent organization of the Accreditation Council for Continuing Medical Education and the Educational Commission for Foreign Medical Graduates, as well as a member organization of

Data Bank is Flawed, American Medical News, Jan. 8, 2001, <http://www.ama-assn.org/public/journals/amnews/amnews.htm>.

¹⁵³ AMA Board of Trustees Report, *supra* note 7, at App. 1, § H-355.987 states, "The AMA affirms its support for the Federation of State Medical Boards Action Data Bank and calls for the dissolution of the National Practitioner Data Bank.". Section H-355.985 of the report further states that "The AMA: (1) opposes all efforts to open the National Practitioner Data Bank to public access; [and] (2) strongly opposes public access to medical malpractice payment information in the National Practitioner Data Bank."

¹⁵⁴ Federation of State Medical Boards, *Facts*, at <http://www.fsmb.org> (last visited Mar. 29, 2001). The Department of Defense provides similar information to the Federation concerning its practitioners. In fact, prior to the operation of the NPDB, the Department of the Navy used reports from the FSMB as part of its credentialing process. Enclosure (4) of Sec. of the Navy Instruction 6320.23, "Credentials Review and Clinical Privileging of Health Care Providers," Feb. 7, 1990 states: "Until such time as the NPDB is active, a report from the Federation of State Medical Boards, or equivalent professional clearing house for non-physicians will be included."

the National Board of Medical Examiners. Additionally, it was the founding member of the American Board of Medical Specialties and has a representative on the board of the National Commission on Certification of Physician Assistants.¹⁵⁵

In addition to numerous other activities, the Federation operates the Board Action Data Bank, which is a nationally recognized system for collecting, recording, and distributing data on disciplinary actions taken against licensees by state licensing and disciplinary boards, the Departments of Defense and Health and Human Services, and other regulatory bodies.¹⁵⁶ In 1998, for example, 4,520 actions (involving quality of care, sexual misconduct, insurance fraud, alcohol/substance abuse, and inappropriate prescribing of controlled substances) were reported to the Federation by medical boards, nearly 3,800 of which were prejudicial to the licensee.¹⁵⁷ Only hospitals, state medical boards, insurers, and government agencies have access to the Federation's data bank information, however.

In response to the recent increased demand for public access to physician-specific information, in April 1999 the President of the Federation established the Special Committee on Physician Profiling.¹⁵⁸ The committee's mission was to review current, publicly available physician profiling information, determine what information would be most helpful to the public, develop an informational guide to be used by the public in interpreting

¹⁵⁵ *Id.*

¹⁵⁶ *Id.* According to the Federation's web site, "to be included in the [Federation's Board Action Data] Bank, an action must be a matter of public record or be legally releaseable to state medical boards or other entities with recognized authority to review physician credentials." Thus, the information duplicates that collected by any individual state medical board; the data bank's appeal lies in the comprehensive, multi-jurisdictional nature of its contents.

¹⁵⁷ *Id.*

¹⁵⁸ *Id.*

profile information, and make a recommendation as to whether or not the FSMB should use data from the All Licensed Physicians Data Bank to develop physician profiles for use by state medical boards and the public.¹⁵⁹

During the summer and fall of 1999 and the winter of 2000, the committee reviewed statutes from states with mandated physician profiles and rules from states with voluntary profiling systems and considered recommendations made by various consumer advocacy groups.¹⁶⁰ Not surprisingly, the committee quickly determined that there is no consistency in the types of physician-specific information reported from state to state, but in general, the committee found that the contents of mandated profiling systems were more comprehensive than their voluntary counterparts.¹⁶¹

The committee compiled its information into a report to be used as a guide for state medical boards and others initiating physician profiling systems.¹⁶² The committee's suggestions were nearly identical to those provided in Representative Bliley's bill.¹⁶³ Profiles should contain only consumer-useful information; the data should be user-friendly, easily understood, and supported by contextual information to help consumers understand the significance of any specific data; and finally, only high quality, credible information subject to verification should be used.¹⁶⁴

¹⁵⁹ *Id.* The All Licensed Physician's Project (ALPP) is designed to be a publicly accessible, Internet-based system that will collect and compile all actions by state medical boards. Initial plans were that the ALPP would include biographical, educational, and licensure information on every physician licensed to practice medicine.

¹⁶⁰ *Id.*

¹⁶¹ *Id.*

¹⁶² *Id.*

¹⁶³ See *supra* notes 2, 64-69 and accompanying text.

¹⁶⁴ *Id.*

Despite having found no studies or market research indicating what consumers really want to know about physicians, but rather, only what consumer advocacy groups have lobbied for on behalf of their constituents, the committee nevertheless made several recommendations regarding the types of information which it felt would be of benefit to consumers. The specific recommendations regarding medical malpractice payments and disciplinary actions are most pertinent to this report.

"[H]ealth care consumers want access to physicians' medical malpractice experience because of the perception that knowing about malpractice judgments will allow them to make better decisions when choosing a physician."¹⁶⁵ According to the report, the committee's resulting recommendation regarding malpractice payment reports reflects its effort to "balance fairness to physicians with a desire to facilitate public disclosure and protection."¹⁶⁶ Because tort law and judicial procedures vary considerably from state-to-state, physician liability data is difficult to place in context outside of a state-based system. Thus, the committee recommended contextual information highlighting several factors consumers should consider when evaluating medical malpractice reports. However, they limited the recommended profile information to the number of medical malpractice court judgments and arbitration awards against the physician within the past 10 years and the number of malpractice settlements when that number is equal to or exceeds 3 in the past 10 years.¹⁶⁷ The committee specifically stated that dollar amounts

¹⁶⁵ *Id.*

¹⁶⁶ *Id.*

¹⁶⁷ *Id.* The contextual factors include statements regarding the lack of correlation between malpractice payments and professional competence, the part that a physician's length and type of practice plays in the likelihood of having malpractice payments made on his behalf, that settlements made by insurance companies should not be construed as creating a presumption that medical malpractice has occurred, and that state medical boards which independently investigate malpractice claims may want to include a statement

of awards, judgments and settlements should not be included for malpractice cases.¹⁶⁸

In the end, the "balance" recommended by the committee seemed more of an attempt to placate a curious public than a solution to using data bank information to make smart consumer choices. A subsequent AMA Board of Trustees report indicated that despite what FSMB's Special Committee on Physician Profiling recommended in its report, the FSMB had no plans to include physician liability information in its Board Action Data Bank,¹⁶⁹ and indeed, that has been the case.

Although the FSMB's most valuable asset is the comprehensive, multi-jurisdictional nature of the information it collects, Kelly C. Alfred, the Manager of the All Licensed Physicians Project, stated that neither medical malpractice payment nor hospital disciplinary action reports will be available through the FSMB's publicly accessible, "DocInfo" web site.¹⁷⁰ In fact, the Federation Physician Data Center, which is the supporting data base for both the Board Action Data Bank and the DocInfo web site, "does not contain malpractice payment information, regardless of a state's ability to provide it."¹⁷¹

in their profile that they do undertake such investigations and discipline in appropriate cases.

¹⁶⁸ *Id.* The committee's reason for excluding this specific information mirrors that made by other organizations who opposed public access to the NPDB, specifically, that dollar amounts are unreliable predictors of physician competence, particularly in the absence of contextual information.

¹⁶⁹ AMA Board of Trustees Report, *supra* note 8, at 5.

¹⁷⁰ E-mail from Kelly C. Alfred, Manager, All Licensed Physicians Project, Federation of State Medical Boards, to Connie Bullock (Feb. 7, 2001, 11:41 CST) (on file with author).

¹⁷¹ E-mail from Kelly C. Alfred, Manager, All Licensed Physicians Project, Federation of State Medical Boards, to Connie Bullock (Mar. 30, 2001, 10:11:58 CST) (on file with author).

Likewise, hospital disciplinary actions will only become part of the Federation's supporting data bank in limited situations. The Federation's Special Committee on Physician Profiling stated that disciplinary actions taken by state medical boards as well as disciplinary actions taken by hospitals which are required to be reported to state medical board should be included in a profile. Unfortunately, not all states require reports of hospital disciplinary actions. At present, hospital disciplinary action against a practitioner is only reported to the FSMB when the action results in state medical board action as well.

Thus, although a consumer will be able to access educational, biographical, and comprehensive licensure information through FSMB's DocInfo web site, both medical malpractice payment reports and hospital disciplinary measures -- the two components that were thought to be so important to physician regulation that they became the impetus for the NPDB -- will remain outside of their grasp through any comprehensive data base.

DocInfo has had few queries, perhaps due in part to its cost (\$9.95 per physician query) and the fact that the FSMB has not publicized its availability. This lack of public response seems to please the AMA. In a turnaround from his Congressional testimony last year, AMA President-elect Richard Corlin, M.D., recently stated that the AMA is not thrilled with the open door policy of the FSMB data bank, but that they would not fight it, adding, "it will be a better source of data than the NPDB."¹⁷² Conversely, the Public Citizen's

¹⁷² AMNews Staff, *FSMB Grants Public Access to its Physician data Bank: Information on Disciplinary Actions Against Physicians Will Now be Available*

Health Research Group (HRG) continues to push to have the NPDB opened to the public, adding that the federation likely opened its data bank "to make money."¹⁷³

In the end, the FSMB's publicly accessible data bank information is nothing more than a national collection of data that most state boards currently collect. Many states have made significant strides to provide physician-specific performance information via the Internet, with varying degrees of success. The next section will discuss the status of such initiatives.

B. State Initiatives

States have historically tracked physician information and are the primary source of information about physicians they regulate.¹⁷⁴ In February 2000, the Public Citizen's Health Research Group (HRG) published the results of a survey they had conducted involving 51 medical boards (representing the 50 states and the District of Columbia) and their current state of Internet-accessible disciplinary information.¹⁷⁵ Like the Special Committee on Physician Profiling, HRG found that the types of information provided varies greatly from state-

to the General Public, But at a Cost," American Medical News, Mar. 5, 2001,
<http://www.ama-assn.org/public/journals/amnews/amnews.htm>.

¹⁷³ *Id.*

¹⁷⁴ Corlin, *supra* note 8.

¹⁷⁵ Demian Larry, et. al., *Public Citizen's Health Research Group Survey of Doctor Disciplinary Information on State Medical Board Web Sites*, Public Citizen, Washington, DC, Feb. 2000, at <http://www.citizen.org/hrg/PUBLICATIONS/1506.htm>.

to-state¹⁷⁶ and of all 51 boards studied, only Maryland provided what HRG considered "adequate" Internet-accessible information.¹⁷⁷

In order to be considered adequate by the surveyors, the information had to include the doctor's name, the offense committed, the disciplinary action taken, a summary narrative of the misconduct, and the full text of the board order.¹⁷⁸ The survey discovered that forty-one state medical boards name disciplined doctors on their web sites, 24 of which were given grades of "B" for content, with the remaining 26 earning anywhere from a "C" to an "X" depending upon the adequacy of information provided.¹⁷⁹ Of the 10 boards that provide no doctor-specific disciplinary action (representing 14 million patients), seven had no web site at all at the time of the survey, and five of the ten said they planned to have sites with disciplinary action information by mid-2000.¹⁸⁰

Interestingly, HRG did find four state sites which report hospital disciplinary actions against physicians (California, Florida, Idaho, and Massachusetts). The same four states, plus Tennessee, provide data

¹⁷⁶ For example, retroactivity of disciplinary data on the web sites ranged from one to 10 years, and there was no consistency on the frequency with which each board updates disciplinary data on their web site or how the data is managed when a board action is vacated, remanded, or overruled by a court. Likewise, "user-friendliness" of web sites varied greatly, causing HRG to recommend that patients be able to retrieve data simply by entering the physician's name or license number.

¹⁷⁷ Demian, *supra* note 175.

¹⁷⁸ *Id.*

¹⁷⁹ *Id.* States providing all five types of data earned a content grade of "A"; states providing four types of data earned a "B", three types of data earned a "C", two types of data earned a "D", and states that named disciplined physicians but provided no details received an "F." States without web sites or those which reported no doctor-specific disciplinary information on their web site earned an "X." One suggested explanation for those with inadequate sites is a lack of adequate funding for the projects.

¹⁸⁰ *Id.*

on malpractice claims, adding that in HRG's opinion, "all states should include such data."¹⁸¹

Although HRG continues to push for a publicly accessible, comprehensive, nationally-based data bank (like the NPDB), their survey resulted in several general recommendations for states to follow in setting up and maintaining their own web sites. HRG listed seven recommendations geared toward ensuring that all states adopt minimum, uniform standards that ensure sufficient information is provided on any reported action; that the information be provided in a user-friendly format; and that the information be comprehensive, current, and retroactive to 10 years.¹⁸² Additionally, HRG provided state-by-state

¹⁸¹ *Id.*

¹⁸² *Id.* The specific recommendations include:

- (1) Each board should have a web site that links to a database of physician information. For each physician disciplined by the board, the information should include the action taken by the board, the offense committed by the physician, and a summary narrative of the physician's misconduct. The database should also feature links to the full text of board orders and other public documents related to the action.
- (2) This information should be provided for all disciplinary actions taken in the last ten years.
- (3) Public access to disciplinary data should be preserved even when a physician's license is suspended, revoked, or expired.
- (4) Patients should be able to retrieve data by entering a physician's name and/or license number in a search engine.
- (5) Disciplinary action information should be updated as frequently as the boards meet to consider actions (usually once a month.)
- (6) If a court overrules or vacates a board action and exonerates the physician and the court decision is final, then information on that action should be removed from the database. While an appeal is pending, or while a remanded action is being considered, information on the action and the court's decision should be reported in the database.
- (7) Any changes in a physician's record resulting from a court decision should be made within two weeks of the court ruling.

recommendations in hopes that their efforts would prompt states into creating web sites that would be maximally useful to their respective residents.

CONCLUSION

Public access to relevant information on physician selection and performance can lead to more intelligent consumer health care choices. With the availability of the Internet, data bank information on physicians and other health care practitioners could be easily accessed with a few computer keystrokes. At the present time, however, there is neither adequate support for nor convincing reasons to open the NPDB to the public.

Health care professionals and related organizations proclaim the potential benefits of publicly accessible, physician-specific information, but then immediately point out the limitations they feel are necessary. More often than not, these powerful organizations successfully block any initiatives to expand either content or access to currently available data banks, including the NPDB. Whether driven by true beneficence or, as is more likely the case, a combination of professional and personal motivations, they were nevertheless correct in their opposition to a publicly accessible NPDB.

Although opponents argue that the NPDB's malpractice payment reporting process for the civilian sector is over-inclusive, the key is in finding the right balance between the databank's legislative mandate and the health care professionals' outcry for fairness. This paper suggests that the peer review

method currently employed within the DoD seems to be an appropriate starting point. While cynics might argue that such a process is akin to the "fox guarding the chicken coop," peer review is not subject to the "gaming" that would accompany the settlement process if arbitrary reporting thresholds were set (i.e., settling for an amount just below the reporting requirement) or if reports were only made for those with multiple malpractice payments in their history. Furthermore, the DoD comparative statistics presented in this paper seem to indicate that the appropriate use of a peer review process prior to reporting to the NPDB results in greater fairness in the overall reporting process. HRSA points out, however, that implementation of a proposal to use a peer review process similar to DoD could require additional congressional action since the NPDB's authorizing legislation does not provide for it.¹⁸³

Likewise, expanded penalty authority (not to mention the willingness to use it) in the area of clinical privileges action reporting would greatly benefit the usefulness and credibility of the NPDB. The progress of any regulatory approach such as this has been generally delayed by the recent change in Administration,¹⁸⁴ but such authority need not be limited to the federal level. In fact, an analysis of the association between state-imposed penalties for failure to report and the level of reporting to NPDB led to the conclusion that states with the strongest penalties also had higher reporting figures.¹⁸⁵ In the meantime, HRSA's Quality Assurance Division has indicated that they have taken on a more proactive approach in reminding health care entities of their reporting obligations.¹⁸⁶

¹⁸³ GENERAL ACCOUNTING OFFICE REPORT, GAO-01-130, *supra* note 28. It should be noted that the NPDB's authorizing legislation does not prohibit expanded use of the peer review process in the context of medical malpractice payment reports either.

¹⁸⁴ Telephone Interview with Mark Pinchus, HRSA, Quality Assurance Division (Apr. 17, 2001).

¹⁸⁵ Baldwin, *supra* note 145.

¹⁸⁶ Pinchus, *supra* note 184.

Continuing support by consumer advocacy groups will likely result in future proposals to open the NPDB to the public. However, without significant changes to the data bank, both in its operation and its contents, such proposals cannot succeed. In the meantime, if the consumer is shopping for comprehensive data on his or her physician -- not necessarily in scope, but from a jurisdictional standpoint -- and is willing to pay the fairly steep price, he can now access the FSMB's DocInfo database.¹⁸⁷ For those who aren't yet willing to pay that amount, but who are willing to devote a bit more time to their research, most states, if not all at the time of this report, have their own Internet accessible physician profiling systems. While such data banks are limited in that they provide only their own jurisdiction's information, with adequate funding and legislative support, some have been able to provide malpractice payment data and hospital disciplinary information at minimal cost to the consumer. Many state medical boards even provide free Internet access to their data banks.

Although it is clearly impossible to support any proposal that the NPDB be thrown open to the public in its current condition, it is equally clear that the time is fast approaching when savvy consumers will demand access to it. It is the single, most comprehensive source of not just the physician information consumers want to have, but information they need to make health care decisions. With procedural revisions and much-needed emphasis on increasing the reliability of its contents, the NPDB fulfill its goal of improving the quality of health care, not just from an institutional perspective, but from a consumer perspective as well.

¹⁸⁷ \$9.95 per physician query.

AD NUMBER	DATE 13 AUG 01	DTIC ACCESSION
1. REPORT IDENTIFYING INFORMATION		REQ4
A. ORIGINATING AGENCY		1. Put y on re
<u>NAVAL POSTGRADUATE SCHOOL, MONTEREY, CA 93943</u>		omp
B. REPORT TITLE AND/OR NUMBER		3. Attach mail
<u>THE NATIONAL PRACTITIONER DATA BANK</u>		4. Use u infor
C. MONITOR REPORT NUMBER		5. Do no for 6
<u>BY CONNIE J. BULLOCK, DEPAUL UNIV</u>		
D. PREPARED UNDER CONTRACT NUMBER		
<u>N62271-97-G-0012</u>		
2. DISTRIBUTION STATEMENT		DTIC:
APPROVED FOR PUBLIC RELEASE: UNLIMITED DISTRIBUTION		1. Assign 2. Return

DTIC F₁
JUL 96

PREVIOUS EDITIONS ARE OBSOLETE

20010816049